

***FRAMEWORK FOR STATE EVALUATION
OF CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT***

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: [State of Iowa](#)

The following State Evaluation is submitted in compliance with Title XXI of the
Social Security Act (Section 2108(b)).

(Signature of Agency Head)

Date: March 31, 2000

Reporting Period: [Medicaid Expansion: July 1, 1998 to September 30, 1999. Healthy and Well Kids in Iowa \(HAWK-I\): January 1, 1999 to September 30, 1999](#)

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

What is the estimated baseline number of uncovered low-income children?

The baseline number of uninsured children in Iowa according to the CPS data is approximately 83,000. CPS data estimated that 67,000 of these children are below 200% of the federal poverty level (FPL) and could potentially qualify for Title XXI if the State expanded eligibility to the full amount authorized under federal law.

Iowa's S-CHIP program covers children only up to 185% of FPL. We estimate the total pool of potentially eligible children below 185% of FPL to be 55,000. Initially, Iowa estimated that approximately 15,500 of these children lived in families with income that does not exceed 133% of FPL and would be covered under the Phase I Medicaid expansion that became effective (statewide) on July 1, 1998.

Iowa also initially estimated that 39,500 uninsured children would qualify for HAWK-I under Phase II of the Title XXI implementation that was effective (in 16 counties) on January 1, 1999, and became statewide on March 1, 1999. We have revised our original estimates to reflect a 75% take-up rate and to reflect that approximately 40% of applicants are being referred to Medicaid. Iowa's estimated enrollment, at program maturity, is now estimated as follows:

16,500 - Phase I Medicaid Expansion
24,750 - Phase II HAWK-I
41,250 - Total S-CHIP Enrollment

Is this estimated baseline the same number submitted to HCFA in the 1998 annual report?

No

1.1.1 What are the data source(s) and methodology used to make this estimate?

Current Population Survey data. The population take-up rate estimate is based on other state's experience with similar programs.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Iowa is utilizing the current population survey.

1.1.3 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XIX outreach, anti-crowd-out efforts)?

The U.S. Census Bureau source of data used to estimate the number of uninsured in Iowa at or below 200% of the federal poverty level, for children less than 19 years of age, three-year average for 1993, 1994, and 1995 equaled 67,000. The federal government along with the state of Iowa utilized this report to project the number of children uninsured that would be eligible for S-CHIP.

The same U.S. Census Bureau source of data three year average for 1996, 1997, and 1998 (dated 1/11/00) estimated the number of children the age of 19 year age, at or below 200% of the federal poverty level equaled 51,000.

Iowa implemented the Phase I, Medicaid expansion effective July 1, 1998. Of the estimated 67,000 uninsured children in Iowa we estimated that 16,500 children would be eligible for Phase I, Medicaid Expansion. Effective January 1, 1999 Phase II, Healthy and Well Kids in Iowa (HAWK-I) was implemented in 16 of Iowa's 99 counties. Statewide coverage under HAWK-I was implemented March 1, 1999. The HAWK-I program covers children up to age 19, at or below 185% of the federal poverty level. Iowa currently estimates that a total of 41,250 uninsured children will become eligible for health coverage under S-CHIP. (Attachment 1)

Children actively enrolled under Title XXI, Phase I, Medicaid expansion on September 30, 1999 totaled 7,793 or 47% of the State's projected goal of 16,500.

Children actively enrolled under Title XXI, Phase II, and HAWK-I on September 30, 1999 totaled 2,809 or 11% of the State's projected goal of 24,750.

The variance between the two U.S. Census Bureau's three-year average reports is 16,000 less uninsured in the state of Iowa. The total number of children insured under S-CHIP, through September 30, 1999 equals 10,602. As of January 2000, when the 1996, 1997, and 1998 report was released, S-CHIP programs in Iowa had enrolled 11,930 uninsured children. The remaining 4,070 children we assume are either covered by regular Medicaid, other third party coverage or fall between 186% and 200% of the federal poverty level. We feel confident that Iowa's S-CHIP program is making a significant impact on the number of children that are uninsured in the state.

1.2.1 What are the data source(s) and methodology used to make this estimate?

Current population survey.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Currently, there is no other more reliable data on which to base estimates. There is concern that the CPS data is out-dated and does not reflect the changes in the economy in recent years.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, and denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3 MEDICAID/MEDICAID EXPANSION

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		

<p>Objective Two:</p> <p>Increase the number of children who have access to health care.</p>	<p>Phase 1: Medicaid Expansion: By July 1, 1998, the capacity within the Iowa Department of Human Services, in the following critical areas, will be appropriately upgraded to meet the target of enrolling 15,600 additional children in the Medicaid program in state fiscal year 1999:</p> <ul style="list-style-type: none"> (1) upgrading data systems with regard to eligibility determination, enrollment, participant information, health services utilization, billing, health status, provider information, etc. (2) staff training (eligibility workers, administrative staff, and support staff), (3) Publications/documents (program manuals, literature for program personnel, consumers and providers, etc.) 	<p>Data Sources: Data systems /Encounter Data/Claims Data</p> <p>Progress Summary: 1) Data systems have been upgraded to provide eligibility determination and enrollment for the Medicaid expansion population. Specific demographic indicators, health services utilization, billing, health status, provider information, etc. are available through the Medicaid tracking system and quality care system. Encounter data is submitted by Medicaid MHC plans and fee for service claims data utilized to track demographic indicators, health services utilization, billing, health status, provider information, etc.</p> <ul style="list-style-type: none"> 2) Staff training (eligibility workers, administrative staff, and support staff) statewide utilizing the statewide Iowa Communication Network (ICN), conference calls, and numerous meeting held in key areas across the state. 3) Publications/documents (program manuals, literature for program personnel, consumers and providers, etc) were developed and distributed statewide. Mass mailings to Department of Human Services regional offices, collaborative agencies (public health, community action agencies etc.) and providers blanketed the state. <p>Outreach efforts and educational seminars continue to take place statewide as the program evolves. Staff have presented at numerous speaking engagements, and are very active in grassroots outreach efforts around the State. In July, 1999 the first outreach conference was held in Des Moines, and 450 attendees representing schools, public health agencies, community action agencies, DHS employees, providers, etc. participated. The second annual outreach conference is scheduled for May 17, 2000. The annual outreach conference has proved to be an excellent forum providing training, strategic outreach planning and an opportunity for attendees to share best practices for signing up potentially eligible children into the S-CHIP program.</p> <p>Enrollment numbers continue to increase.</p>
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OBJECTIVES RELATED All Children participating in the program would have a medical home.		
<p>Objective Five:</p> <p>All children participating in the program will have a medical home.</p>	<p>By February 1, 1999, at least 50% of those children enrolled (except those exempted from participation in managed care such as children in foster care) will have a medical home as evidenced by documented assignment of provider through the Medipass program or Medicaid HMO.</p>	<p><u>Data Sources:</u> Medicaid Fiscal Agent</p> <p><u>Methodology:</u> When a child is enrolled in Medicaid they are assigned a primary care physician via Medicaid's Managed Care Fiscal Agent, unless the managed health care plan administers their plan as open access.</p> <p><u>Progress Summary:</u> Medicaid's managed care fiscal agent generates a monthly report that identifies enrollee/PCP assignment.</p>
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		

<p><u>Objective One:</u></p> <p>Increase the health status of children in Iowa.</p>	<p>By January 1, 2000, the following health status and health care system measures will show acceptable incremental improvements for at least the following:</p> <ol style="list-style-type: none"> 1) Seventy-five percent of enrolled children will be appropriately immunized at age two, excluding varicella immunizations. The clinical advisory committee will establish a baseline rate for comparison for varicella. 2) Eighty percent of enrolled children will participate in EPSDT and receive a well-child visit, as measured by the HCFA 416 (Annual EPSDT Participation Report) participation ratio. 4) Eighty percent of enrolled children will have received at least one preventative dental visit annually. 	<p><u>NOTE: Medicaid Expansion is not reported separately. Reports are generated for the total Medicaid population.</u></p> <p><u>Data Sources:</u> Encounter Data and MCO Hedis reports.</p> <p><u>Methodology:</u> The percentage of children 6-month through 12 years of age that have received recommended vaccinations. (Attachment 2).</p> <p><u>Progress Summary:</u> Health plans provide immunization reports quarterly</p> <p><u>Data Source:</u> Managed Care Organization and Third Party Fiscal Agent. Encounter data and PCCM claims data are utilized to generate the report.</p> <p><u>Methodology:</u></p> <ol style="list-style-type: none"> 1) Number of cumulative months of enrollment in the plan in the 12 months prior to the end of this reporting period. 2) Number of children in the reporting period within each month of enrollment stratum. 3) Number of children with EPSDT visits per Column 4 during the reporting period. 4) Number of EPSDT visits to fall within acceptable range for purpose of this report. 5) Total number of EPSDT visits for all children reported in number 2 above. 6) Average number of EPSDT visits per child. <p><u>Progress Summary:</u> EPSDT screening reports are submitted quarterly by the health plans and generated by Medicaid claims payment system. (Attachment 3)</p> <p><u>Data Source:</u> Dental claims data.</p> <p><u>Methodology:</u> For designated dental claims with a procedure code (identified) for recipients identified as Medical Expansion.</p> <p><u>Progress Summary:</u> Reports are not available for this reporting period. Data from this reporting period (year one) will be used to set a baseline by which future data will be measured.</p>
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Other Objectives		
<p>Objective Three: Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g. asthma)</p> <hr/> <p>Objective Four: Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting (e.g. otitis media).</p>	<p>Percent of children admitted inpatient for asthma.</p> <hr/> <p>Reduce the number of emergency room visits for treatment of non-emergent medical conditions.</p>	<p>Data Sources: Encounter Data and Third party administrator claims data</p> <p>Progress Summary : Reports are not available for this reporting period. Data from this reporting period (year one) will be used to set a baseline by which future data will be measured.</p> <hr/> <p>Data Sources: Encounter data and Third Party Administrator claims data.</p> <p>Progress Summary : Reports are not available for this reporting period. Data from this reporting period (year one) will be used to set a baseline by which future data will be measured.</p>

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
HAWK-I		
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		

<p>Objective Two:</p> <p>Increase the number of children who have access to health care.</p>	<p>Phase II: HAWK-I: By January 1, 1999, the capacity within the Iowa Department of Human Services, in the following critical areas, will be appropriately upgraded to meet the target of enrolling 39,500 additional children in the HAWK-I program by the end of year 2:</p> <ul style="list-style-type: none"> (4) upgrading data systems with regard to eligibility determination, enrollment, participant information, health services utilization, billing, health status, provider information, etc. (5) staff training (eligibility workers, administrative staff, and support staff), (6) publications/ documents (program manuals, literature for program personnel, consumers and providers, etc.) 	<p>Data Sources: Encounter Data/ Evaluation and management codes.</p> <p>Methodology :Measure of access to primary care providers for preventative/ambulatory services for children (outreach, accessibility (group 1) and expected access (group 2)</p> <p>Numerator: <u>Measure of interest:</u></p> <p>Group 1: Unduplicated number of enrollees who have had one (or more) visits to a health plan practitioner in the reporting period.</p> <p>Group 2: Unduplicated number of enrollees who have had one (or more) visits to a health plan practitioner in the reporting period.</p> <p>Denominator: <u>Population definition.</u></p> <p>Group 1: All enrollees under 12months, 12 months to 5 years, 6 years to 12 years, 13 year to 18 years enrolled for 5-10 months in the program in a given time period.</p> <p>Group 2: All enrollees under 12months, 12 months to 5 years, 6 years to 12 years, 13 year to 18 years enrolled for 11-12 months in the program in a given time period.</p> <p><u>Progress Summary:</u></p> <ul style="list-style-type: none"> 1) HAWK-I's third party administrator's data systems have been upgraded to provide eligibility and enrollment data for the HAWK-I population. This data is utilized to track demographic indicators. Health services utilization, billing, health status, provider information, etc. is submitted by the plans to the third party administrator via encounter data. 2) Staff training eligibility workers, administrative staff and support staff utilize the Iowa Communication Network (ICN), conference calls, and attend numerous meetings held in key areas across the state. Additionally, a "grassroots" community based outreach plan has been developed. 3) Publications/documents (program manuals, literature for program personnel, consumers and providers, etc) were developed and distributed statewide. Mass mailings to Department of Human Services regional offices, collaborative agencies (public health, community action agencies etc.) and providers blanketed the state. <p>At least 24,750 (adjusted, refer to section 1) uninsured children will be enrolled in the HAWK-I program by the end of year 2.</p> <p>Outreach efforts and educational seminars continue to take place statewide as the program evolves. Staff have presented at numerous conferences, and are very active in grassroots outreach efforts around the State. In July, 1999 the first outreach conference was held in Des Moines, 450 attendees representing schools, public health agencies, community action agencies, DHS employees, providers, etc. participated. The second annual outreach conference is scheduled for May 17, 2000. The annual outreach conference has proved to be an excellent forum providing training, strategic outreach planning and an opportunity for attendees to share best practices for signing up potentially eligible children into the S-CHIP program.</p> <p>Note: HAWK-I Functional Baseline Survey is also being utilized.</p> <p>Enrollment numbers continue to increase.</p>
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OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)

<p><u>Objective One:</u></p> <p>Increase the health status of children in Iowa.</p>	<p>By January 1, 2000, the following health status and health care system measures will show acceptable incremental improvements for at least the following:</p> <ol style="list-style-type: none"> 1) Seventy-five percent of enrolled children will be appropriately immunized at age two, excluding varicella immunizations. The clinical advisory committee will establish a baseline rate for comparison for varicella. 2) Eighty percent of enrolled children will have received at least one preventative dental visit annually. 3) Two, Three, Four, Five and Six Year Old Well Child Visits <p>Adolescent Comprehensive Well-Care Visits</p>	<p><u>Data Sources</u> : Encounter Data <u>Methodology</u>: Rate of appropriate childhood immunizations at age 2. (Hedis) <u>Numerator</u> : All children turning 2 years during the quarter preceding the reporting period quarter. <u>Denominator</u>: Unduplicated number of children 2 year of age fully immunized. <u>Goal</u>: 75% of 2 year olds will be appropriate immunized at age 2. <u>Progress Summary</u>: An adequate baseline has not been established for this reporting period because the program had been up and running less than one year. Data from year one will be used to establish a baseline from which to measure progress in subsequent years.</p> <p><u>Data Sources</u> : Encounter Data <u>Methodology</u>:The percentage of HAWK-I enrolled member's aged 4 – 19 who had at least one dental visit during the reporting year.. (Hedis Numerator and Denominator) <u>Goal</u>: 80% of identified population will have received at least one preventative visit. <u>Progress Summary</u>: An adequate baseline has not been established for this reporting period because the program had been up and running less than one year. Data from year one will be used to establish a baseline from which to measure progress in subsequent years.</p> <p><u>Data Source</u>: Encounter Data <u>Methodology</u>: : The percentage of enrolled two, three, four, five and six years old, who have received a well-child visit with a primary care physician. (Hedis) <u>Numerator</u>: The number of children in the denominator who received at least one well-child visit with a primary care provider during the reporting year. A child receives a well-child visit if he or she has a claim/encounter with a primary care provider that meeting set criteria... <u>Denominator</u>: The number of children two, three, four, five and six years old as of <u>(Month)</u> of the reporting year and who were continuously enrolled during the reporting year (allowing for one break in service, not to exceed 30 days or one month). <u>Data Source</u>: Encounter Data <u>Methodology</u>: The percentage of HAWK-I enrolled adolescents aged 12 to 19 during the reporting year who had one or more comprehensive well-care visits with a primary care provider during that year. (Hedis) <u>Numerator</u>: The number of HAWK-I enrolled adolescents, aged 12 to 19 as of <u>(Month)</u> of the reporting period, who were members of the plan as of <u>(Month)</u> of the reporting year, and who were continuously enrolled (allowing for one break in service, not to exceed 30 days or one month) during the reporting period. <u>Denominator</u>: The number of HAWK-I enrolled adolescents, aged 12 to 19 as of <u>(Month)</u> of the reporting period, who were members of the plan as of <u>(Month)</u> of the reporting year, and who were continuously enrolled (allowing for one break in service, not to exceed 30 days or one month) during the reporting period. <u>Progress Summary</u>: An adequate baseline has not been established for this reporting period because the program had been up and running less than one year. Data from year one will be used to</p>
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OTHER OBJECTIVES

Objective Three:

Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g. asthma)

Percent of children admitted inpatient for asthma.

Data Sources: Encounter Data (UB-82/92)

HEDIS

Methodology: The percentage of HAWK-I enrollees aged 2-19, continuously enrolled during the prior 12-month period (allowing one break in service per year, not to exceed 30 days or one month per year), with inpatient admissions for the care of asthma in the health plan during a calendar year.

Numerator: The number of HAWK-I members in the denominator with two or more equivalent inpatient discharges with a principal diagnosis of asthma.

Denominator: The number of HAWK-I enrollees aged 2-19 years as of (Month) of the reporting period, who were members as of (Month) of the reporting year (allowing for one break in service, not to exceed 30 days or one month) AND who are identified as asthmatic using one of two methods.

Progress Summary: An adequate baseline has not been established because the program had been up and running less than one year. Data from year one will be used to establish a baseline from which to measure progress in subsequent years.

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Objective Four:

Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting (e.g. otitis media).

Reduce the number of emergency room visits for treatment of non-emergent medical conditions.

Data Sources: Encounter data

Methodology: The percentage of HAWK-I enrollees aged 2-19, continuously enrolled during the prior 12-month period (allowing one break in service per year, not to exceed 30 days or one month per year), with emergency room visit for the care of non-emergent medical condition.

Progress Summary: An adequate baseline has not been established because the program had been up and running less than one year. Data from year one will be used to establish a baseline from which to measure progress in subsequent years.

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SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

X Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: Medicaid

Date enrollment began (i.e., when children first became eligible to receive services):

July 1, 1998

X Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: Healthy and Well Kids in Iowa (HAWK-I)

Date enrollment began (i.e., when children first became eligible to receive services):

January 1, 1999 (in 16 counties)

March 1, 1999 (Statewide)

NA Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):

NA Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):

NA Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):

NA Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services):

2.1.2 If State offers family coverage: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

The State of Iowa does not offer family coverage.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

Iowa does not buy-in to employer sponsored plans under S-CHIP.

2.2 What environmental factors in your State affect your CHIP program?

(Section 2108(b)(1)(E))

Limited numbers of primary care physicians in rural areas of the state, limited number of dentists statewide that are accepting new patients; limited number of specialists and sub-specialists in rural areas (especially psychiatric services). Iowa is aware of the issues and is actively pursuing opportunities to recruit and retain college graduate physicians and dentists in the State. Additionally, we are experiencing an increase in minority populations (see 2.2.3 for anticipated percentage increases).

Many of the new immigrants do not speak English and come from countries with socialized medicine. They do not understand the concept of "insurance". Additionally, some are undocumented and will not access care for their citizen children due to fears of deportation.

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Iowa's Medicaid program had differing eligibility criteria based on age and family income of the child. Because of this "stair step" approach to eligibility, there were families in which some children were Medicaid eligible while others were not. It was our goal to design the S-CHIP program to level out the income threshold for Medicaid in order to provide coverage to all children within a family.

Were any of the preexisting programs “State-only” and if so what has happened to that program?

 X No pre-existing programs were “State-only”

One or more pre-existing programs were “State only” ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 **Describe changes and trends in the State since implementation of your Title XXI program that “affect the provision of accessible, affordable, quality health insurance and healthcare for children.” (Section 2108(b)(1)(E))**

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

X Changes to the Medicaid program

No Presumptive eligibility for children

Yes Coverage of Supplemental Security Income (SSI) children (already in place).

No Provision of continuous coverage (specify number of months ____)

Yes Elimination of assets tests (for children only) Effective 7-1-99.

Yes Elimination of face-to-face eligibility interviews (for children only) Effective 7-1-99.

No Easing of documentation requirements

X Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF

Iowa's strong economy and Welfare reform's push to make people self-sufficient has led to an overall decline of ____4____% (February, 1998 – September, 1999) in the Medicaid roles. However, while Medicaid in general has declined, the number of children in Medicaid (regular and expansion) has increased by 5% (July , 1998 – September 1999).

With the "delinking" of Medicaid and cash assistance, Iowa took great care to ensure that people did not lose Medicaid eligibility simply because they lost eligibility for cash assistance. This was accomplished by delinking the computer systems so that separate eligibility determinations are completed for each program.

X Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

____ Health insurance premium rate increases

____ Legal or regulatory changes related to insurance

____ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)

____ Changes in employee cost-sharing for insurance

____ Availability of subsidies for adult coverage

X Other (specify) Proposed mental health parity laws have the potential to impact all items listed above.

☒ **Changes in the delivery system**

☒ **Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)**

☒ **Changes in hospital marketplace (e.g., closure, conversion, merger)**

_____ Other (specify) _____

☒ **Development of new health care programs or services for targeted low-income children (specify) Healthy and Well Kids in Iowa program (HAWK-I)**

☒ **Changes in the demographic or socioeconomic context**

☒ **Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify) The state of Iowa is projecting that Iowa's Caucasian population will grow by 2.6 percent by 2025. The African-American population is expected to grow by 4.7 percent, the Asian population by 77 percent, Hispanic population by 77 percent and the Native American Indian population by 56 percent.**

☒ **Changes in economic circumstances, such as unemployment rate (specify) The unemployment rate in Iowa was 2.4 percent in February, 2000. Iowa is committed to attract new industries, which will, in turn, provide new jobs.**

However, many of the new jobs are in the service industry, which traditionally has not provided adequate health care coverage to the dependents of employees.

☒ **Changes in the number of children insured since the implementation of CHIP programs . As indicated in 1.1.3 the variance between the two U.S. Census Bureau three-year average reports is 16,000 less uninsured in the state of Iowa. The total number of children insured under S-CHIP, Medicaid expansion and HAWK-I through September 30, 1999 equals 10,602. As of January, 2000, when the 1996, 1997, 1998 report was released by the Census Bureau, S-CHIP programs in Iowa had enrolled 11,930 uninsured children. We assume the remaining 4,070 children are either covered by regular Medicaid or have obtained coverage through other third party insurance.**

_____ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

- 3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter “NA.”

Table 3.1.1			
	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____ _____
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	January 1, 1999 - February 28, 1999 - 16 counties. March 1, 1999 - statewide Various geographic areas are served by specific health plans.(refer to HAWK-I health plan coverage map attached)	
Age	6 to 19 years	0 to age19 .	

Income (define countable income)	<p>There are no differences in how income is considered for children on the regular Medicaid program and those on the Medicaid expansion.</p> <p>Generally, the state uses the income methodology in place for the TANF program to determine countable income for Medicaid as follows:</p> <p>Gross Earned Income</p> <ul style="list-style-type: none"> - 20% earned income disregard - child care expenses + <u>unearned income</u> <p>= countable income</p> <p>Other deductions to income may be allowed in specific situations.</p>	<p>When determining initial and ongoing eligibility for the HAWK-I program, all earned and unearned income, unless specifically exempted, shall be countable. Countable income shall not exceed 185% of the federal poverty level for a family of the same size. (See attached rules defining earned and unearned income)</p>	
Resources (including any standards relating to spend downs and disposition of resources)	<p>Resources are disregarded for children under age 19.</p> <p>Effective 7-1-99.</p>	<p>There is no resource test in the HAWK-I program.</p>	

Residency requirements	<p>A person must:</p> <ul style="list-style-type: none"> • Be living in the state with intent to remain permanently, or • Have come to the state with a job offer or to seek employment 	<p>A person must:</p> <ul style="list-style-type: none"> • Be living in the state with intent to remain permanently, or • Have come to the state with a job offer or to seek employment 	
Disability status	Disability is not an eligibility factor for these children.	Disability is not an eligibility factor for these children.	
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	Social security number or proof of application is required.	Access to health coverage is not considered except in the case of dependents of State of Iowa employees. In which case, they are not eligible, regardless of whether coverage exists.	
<p>Other standards</p> <p>Social Security Number</p> <p>Citizenship</p>		Social security number is not required.	

**Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Monthly	Families with earned income, or unstable unearned income, or with a recent work history report financial and household composition data monthly.	NA	
Every six months	Families with no income and no recent work history, or no earned income and only stable unearned income are reviewed semi-annually.	NA	
Every twelve months	All cases have all eligibility factors reviewed annually, many with an in-person interview.	All cases are redetermined for eligibility annually.	
Other (specify)			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

☒ **Yes** ° Which program(s)? **HAWK-I**

For how long?

HAWK-I: Twelve months unless the child becomes Medicaid eligible, the child becomes pregnant (in which case they are evaluated for Medicaid), the child is institutionalized, the child attains insurance coverage, turns 19, or moves outside the state of Iowa with the intent of gaining residency in the other state.

☐ No = Which program(s)?

3.1.4 Does the CHIP program provide retroactive eligibility?

☒ **Yes** ° Which program(s)? **Medicaid expansion only.**

How many months look-back? **3 months**

☐ No

3.1.5 Does the CHIP program have presumptive eligibility?

☐ **Yes** ° Which program(s)?

Which populations?

Who determines?

☒ **No**

3.1.6 Do your Medicaid program and CHIP program have a joint application?

X Yes = Is the joint application used to determine eligibility for other State programs? If yes, specify. All HAWK-I applications are screened for Medicaid eligibility. If it appears that Medicaid eligibility exists, the HAWK-I application becomes a Medicaid application and is referred to the Medicaid eligibility workers that are co-located with the HAWK-I staff. When HAWK-I makes a referral to Medicaid a supplemental form is sent to the applicant along with a letter advising them that they are being referred to Medicaid.

When an application for Medicaid is denied, the application is referred to HAWK-I if it appears the children would qualify. The family being referred from Medicaid is not required to fill out the two-page HAWK-I application in addition to the Medicaid application. (Attachment 4)

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Medicaid Expansion:

Iowa's *eligibility determination* process requires that the eligibility worker examine eligibility under any and all Medicaid coverage groups before deciding that an applicant is not eligible. This process has been in place for many years and we believe that this process greatly reduces the potential for people being incorrectly denied Medicaid eligibility.

Strengths:

- No interview is required.
- No resource test
- Can accept HAWK-I's application.

Weaknesses:

- The joint application with TANF and Food Stamps is too long.
- Absent parent information is requested prior to approval.
- Stigma of Medicaid by the public.

HAWK-I: Applications are submitted to the third party administrator by mail. The HAWK-I brochure includes an easy two-page application and a self-addressed postage paid envelope. Once a completed application is submitted to the third party administrator, the application is processed within 10 working days of receipt. If the applicant is otherwise eligible they are enrolled with a health plan.

A 24 hour, toll free, customer service center is available to assist in the completion of the applications and to answer questions.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Medicaid eligibility is based on retrospective income and prospective eligibility on a monthly basis. Monthly redetermination is cumbersome for families and contributes to disenrollment for non-compliance.

The HAWK-I program has 12-month continuous eligibility. The program was implemented in 16 counties on January 1, 1999 and the remainder of the state March 1, 1999. Therefore, the redetermination process was not implemented during the reporting period.

Medicaid Expansion:

Iowa's automatic *redetermination* process requires that the eligibility worker examine eligibility under all Medicaid coverage groups before deciding that Medicaid eligibility no longer exists. This process has been in place for many years and we believe that this process greatly reduces the potential for people having their Medicaid coverage incorrectly canceled.

Strengths:

No interview is required.

An eligibility redetermination can usually be made from the information provided on the monthly report.

Weaknesses:

Monthly reporting required in most cases.

No edit if the worker fails to do a redetermination.

May result in children being covered only when they need services. Thus, resulting in adverse selection into the program.

How does this differ from the initial eligibility determination?

No application is necessary. A redetermination is usually based on information already in the file.

3.2 What benefits do children receive and how is the delivery system structured?
(Section 2108(b)(1)(B)(vi))

3.2.1 Benefits (**Attachment 5**)

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type <u>HAWK-I</u> <u>Wellmark Classic Blue (Indemnity) and Wellmark Unity Choice (HMO) Health Plans</u>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits
Inpatient hospital services	T= yes	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Emergency hospital services	T	Enrollees whose income falls between 150% and 185% of the FPL Are charged a \$25.00 copay if ER services are utilized that <u>do not</u> fall within prudent layperson protocol.	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Outpatient hospital services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Physician services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Clinic services (Outpatient physician clinic services)	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Prescription drugs	T	Pay nothing when: 1. Generic drugs are used whenever there is a generic equivalent for the drug you are taking. 2. Brand name drugs are covered if a generic equivalent is not available.	Preferred drug list Maximum quantity of medication: Retail prescriptions: a 30 day supply or 100 units, whichever is less Retail maintenance prescriptions: a 30 day supply Mail Order Prescriptions: A 30 day supply
Over-the-counter medications	No		

Outpatient laboratory and radiology services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Prenatal care	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Family planning services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Inpatient mental health services	T	None	Limited to 30 days per year (Maximum combined for mental health and substance abuse)
Outpatient mental health services	T	None	Limited to 30 visits/year (Maximum combined with substance abuse)
Inpatient substance abuse treatment services	T	None	Limited to 30 days per year (Maximum combined for mental health and substance abuse)
Residential substance abuse treatment services	No		
Outpatient substance abuse treatment services	T	None	Limited to 30 days per year (Maximum combined for mental health and substance abuse)
Durable medical equipment	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Disposable medical supplies	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.

Preventive dental services	T	None	<p>Diagnostic and Preventative Services</p> <ol style="list-style-type: none"> 1. Oral Evaluations (only twice/year) 2. Dental cleaning (only twice/year) 3. Topical fluoride applications (once every 12 consecutive months) 4. X-rays: bitewing once every 12 consecutive months; full mouth once every 5 consecutive years, occlusal and extraoral x-rays once every 12 consecutive months 5. Sealant application for children under 15, once per permanent first and second molars in a lifetime 6. 0Space maintainers for missing back teeth, for eligible children under 15. 7. Annual dental limit is \$1,000 per year.
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Restorative dental services	T	None	<p>Routine and Restorative Services:</p> <ol style="list-style-type: none"> 1. Emergency treatment (palliative) 2. Contour of bone (alveoloplasty) 3. General anesthesia/sedation 4. Restoration of decayed or fractured teeth 5. Limited occlusal adjustment 6. Routine oral surgery <p>Endodontic Services:</p> <ol style="list-style-type: none"> 1. Apicoectomy/periradicular surgery 2. Direct pulp cap 3. Pulpotomy 4. Retrograde fillings 5. Root canal therapy <p>Periodontal Services:</p> <ol style="list-style-type: none"> 1. Conservative periodontal procedures (root planing and scaling) – once every 24 consecutive months for each quadrant 2. Complex periodontal procedures – once every 3 consecutive year for each quadrant of the mouth 3. Periodontal maintenance therapy – must follow conservative or complex periodontal therapy – up to 4 times/12 month period & then once every 6 months. <p>Cast restorations for complicated tooth decay or fracture –crowns, inlays, onlays, posts and cores</p> <p>\$1000 benefit period maximum</p>
Hearing screening	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Hearing aids	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.

Vision screening (by a optometrist or ophthalmologist, vision screening are also provided when the child receives a physical by their primary care provider.)	T	If the exam is over \$50.00 the enrollee is responsible for the balance.	One vision exam every 12 months. Limit: exam \$50.00
Corrective lenses (including eyeglasses)	T	Maximum: one frame with lenses \$100.00. Enrollee responsible for balance.	One frame every 12 months Limit: One frame with lenses \$100.00.
Developmental assessment	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Immunizations	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Well-baby visits	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Well-child visits	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Physical therapy	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Speech therapy	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Occupational therapy	T	None	Occupational therapy supplies are excluded. Services only to treat the upper extremities, which means the arms from the shoulders to the fingers.

Physical rehabilitation services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Podiatric services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Chiropractic services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Medical transportation (Ambulance Services air or ground))	T	None (for ambulance services only professional air or ground)	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition. (Ambulance Services air or ground))

Home health services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Nursing facility	No	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
ICF/MR	No		
Hospice care	T	None	Inpatient 15 days, outpatient 15 days.
Private duty nursing (inpatient covered)	No		
Personal care services	No		
Habilitative services (short term rehab is covered)	No		
Case management	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Non-emergency transportation	No		
Interpreter services	No **		
<u>Life Time Maximum</u>			Lifetime maximum benefit \$1,000,000 per member.
<u>Definition for Medically Necessary</u>			Refer to the attached Evidence of Coverage for the definition of Medically Necessary.
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 3.2.1 CHIP Program Type <u>HAWK-I (Iowa Health Solutions Health Plan –HMO)</u>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Emergency hospital services	T	Enrollees whose income falls between 150% and 185% of the FPL are charged a \$25.00 copay if ER services are utilized that <u>do not</u> fall within prudent layperson protocol.	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Outpatient hospital services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Physician services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Clinic services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.

Prescription drugs	T	None (If the patient otherwise request and obtain a brand name drug, they will be responsible for the difference of cost	<p>Non-Covered Items, Exclusions, Limitations:</p> <p>A. Each prescription is limited to a maximum of a 30 day supply.</p> <p>B. All prescriptions and refills must be filled with generic drugs except when an approved alternative to brand name drugs is not available or the prescribing physician has indicated “no generic substitution”. If you otherwise request and obtain a brand name drug, You will be responsible for the difference of cost.</p> <p>C. Drugs purchased for future use are limited to a three (3) month supply or a maximum quantity for maintenance legend drugs of a 100 unit dose, whichever is less</p> <p>D. The following items are not covered:</p> <ol style="list-style-type: none"> 1. Non-prescription drugs 2. Drugs prescribed primarily for cosmetic use
Over-the-counter medications	No		
Outpatient laboratory and radiology services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Prenatal care	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Family planning services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Inpatient mental health services	T	None	Up to 60 days per calendar year.
Outpatient mental health services	T	None	Up to 20 visits per calendar year.

Inpatient substance abuse treatment services	T	None	Lifetime benefit is \$39,000 for inpatient and outpatient substance abuse and alcohol services. Up to \$9,000 per calendar year.
Residential substance abuse treatment services	No		
Outpatient substance abuse treatment services	T	None	Lifetime benefit is \$39,000 for inpatient and outpatient substance abuse and alcohol services. Outpatient treatment: Up to \$1,500 per calendar year. Outpatient Counseling: Up to \$2,500 per calendar year.
Durable medical equipment	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Disposable medical supplies	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Preventive dental services	T	None	\$1,500 annual maximum benefit per person per year
Restorative dental services	T	None	\$1,500 annual maximum benefit per person per year
Hearing screening	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Hearing aids	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Vision screening	T	None	Refractions are limited to one per member per calendar year.

Corrective lenses (including eyeglasses)	T	None	Coverage is provided for prescribed corrective lenses and eyeglasses frames with a maximum reimbursement of \$100 as follows: 1. Frames: One per member per two (2) calendar years. 2. Prescribed Corrective Lenses. One per member per calendar year.
Developmental assessment	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Immunizations	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Well-baby visits	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Well-child visits	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Physical therapy	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Speech therapy	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition. Speech therapy, which is educational in nature and any other education, services which are provided through the schools.

Occupational therapy	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Physical rehabilitation services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Podiatric services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Chiropractic services	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Medical transportation (Ambulance air and ground only) The plan does not pay for enabling services.	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Home health services	T	None	Home care (nursing therapy, etc) provided through home health agency and prescribed by Primary Care Physician in lieu of hospital or nursing care facility. Limit 40 visits per calendar year.
Nursing facility	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
ICF/MR	No		
Hospice care	T	None	Includes up to 12 bereavement counseling visits. Outpatient: Up to \$2,000 in coverage per calendar year. Inpatient: Up to \$3,000 in coverage per calendar year.
Private duty nursing (inpatient covered)	No		

Personal care services	No		
Habilitative services (short term rehab is covered)	No		
Case management	T	None	None unless the overall plan benefit maximum limits are reached or services fall outside the plans medically necessary definition.
Non-emergency transportation	No		
Interpreter services	No		
<u>Life Time Maximum</u>			Lifetime maximum benefit \$1,000,000 per member.
<u>Definition for Medically Necessary</u>			Refer to the attached Evidence of Coverage for the definition of Medically Necessary.

Table 3.2.1 CHIP Program Type <u>Medicaid Expansion</u>			
Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T	None	None unless services fall outside medically necessary definition.
Emergency hospital services	T	None	None unless services fall outside medically necessary definition.
Outpatient hospital services	T	None	None unless services fall outside medically necessary definition.
Physician services	T	None	None unless services fall outside medically necessary definition.
Clinic services	T	None	None unless services fall outside medically necessary definition.
Prescription drugs	T	None	None unless services fall outside medically necessary definition.
Over-the-counter medications	T	None	Only by prescription
Outpatient laboratory and radiology services	T	None	None unless services fall outside medically necessary definition.
Prenatal care	T	None	None unless services fall outside medically necessary definition.

Family planning services	T	None	None unless services fall outside medically necessary definition.
Inpatient mental health services	T	None	None unless services fall outside medically necessary definition.
Outpatient mental health services	T	None	None unless services fall outside medically necessary definition.
Inpatient substance abuse treatment services	T	None	None unless services fall outside medically necessary definition.
Residential substance abuse treatment services	T	None	None unless services fall outside medically necessary definition.
Outpatient substance abuse treatment services	T	None	None unless services fall outside medically necessary definition.
Durable medical equipment	T	None	None unless services fall outside medically necessary definition.
Disposable medical supplies	T	None	Limitation on cost via home health and physician office

Preventive dental services	T	None	<p>Preventive Services:</p> <ul style="list-style-type: none"> • Oral prophylaxis (cleaning) is covered once every six months, except for persons with a physical or mental disability who need more frequent care. • Topical application of fluoride once every six months, and only when preceded by prophylaxis. • Sealants are covered for first and second permanent molars only, one application per tooth in a lifetime and only for children through 15 years of age. (This will be increased to 18 years with a pending rule change.) <p>Diagnostic Services:</p> <ul style="list-style-type: none"> • A comprehensive oral evaluation is covered once per patient per dentist. (This will be changed to once per patient per dentist in a 3 year period with a pending rule change.) • A periodic oral evaluation is covered once every six months. • A complete mouth x-ray survey consisting of a minimum of 14 periapical films and bite-wings films is covered once every five years, unless otherwise medically necessary. It is not covered under the age of six. • Supplemental bitewing films are covered once every 12 months. • Intraoral and extraoral films are covered when necessary to diagnose a condition.
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Restorative dental services	T	None	<p>Restorative Services:</p> <ul style="list-style-type: none"> • Treatment of dental caries requiring immediate attention is covered. Restoration of incipient or nonactive carious lesions is not covered. • Amalgam alloy and composite restoration are covered. Composite restorations are limited to once every two years. • Porcelain crowns are limited to two per year. There is no limit to stainless steel crowns. Noble metals are covered when the patient is allergic to all other restorative materials. <p>Endodontic Services:</p> <ul style="list-style-type: none"> • Root canal treatments are covered for permanent anterior and posterior teeth when extensive post treatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches. <p>Oral Surgery:</p> <ul style="list-style-type: none"> • Surgical and nonsurgical extractions are covered when medically necessary. • General anesthesia and intravenous sedation are covered when the extensiveness of the procedure indicates it or there is a disease or impairment, which warrants its use. • Additional payment for postoperative care is covered when the need is beyond normal follow up care or the original service was performed by another dentist. <p>Prosthetic Services:</p> <ul style="list-style-type: none"> • Removable partial dentures for front teeth are covered once every five years unless lost, stolen, broken beyond repair or no longer fit. • Removable partial dentures for posterior teeth require prior approval and are covered when fewer than eight posterior teeth are in occlusion. • Fixed partial dentures are covered when the recipient has a medical condition that precludes use of a removable partial denture. <p>Orthodontic Services:</p> <ul style="list-style-type: none"> • Orthodontic procedures require prior approval and are covered only for the most severe handicapping malocclusions based on a Salzman score. Eight units of a three-month active treatment are covered. Additional units may be allowed if found to be medically necessary. • Space management services are covered when medically necessary. • Tooth guidance is covered up to a maximum of \$125.
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Hearing screening	T	None	None unless services fall outside medically necessary definition.
Hearing aids	T	None	None unless services fall outside medically necessary definition.
Vision screening	T	None	Limited to one vision screening per year.
Corrective lenses (including eyeglasses)	T	None	Limited to one frame every two years. Lenses are limited to one prescription per year.
Developmental assessment	T	None	None unless services fall outside medically necessary definition.
Immunizations	T	None	None unless services fall outside medically necessary definition.
Well-baby visits (EPSDT)	T	None	None unless services fall outside medically necessary definition.
Well-child visits (EPSDT)	T	None	None unless services fall outside medically necessary definition.
Physical therapy	T	None	None unless services fall outside medically necessary definition.
Speech therapy	T	None	None unless services fall outside medically necessary definition.
Occupational therapy	T	None	None unless services fall outside medically necessary definition.
Physical rehabilitation services	T	None	None unless services fall outside medically necessary definition.

Podiatric services	T	None	None unless services fall outside medically necessary definition.
Chiropractic services	T	None	<p>Chiropractic manipulative treatment (CMT) generally require short, moderate, or long-term CMT. A diagnosis or combination of diagnosis within</p> <ul style="list-style-type: none"> • Category I (short-term) is equal to CMT of 12 per 12 month period. . • Category II (moderate-term) is equal to CMT of 18 per 12 month period. • Category III (long-term) is equal to CMT of 24 per 12-month period. • For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. • If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.
Medical transportation	T	None	None unless services fall outside medically necessary definition.
Home health services	T	None	None unless services fall outside medically necessary definition. Must be pre-certified.
Nursing facility	T	None	None unless services fall outside medically necessary definition. Must be pre-certified.
ICF/MR	T	None	None unless services fall outside medically necessary definition. Must be pre-certified.
Hospice care	T	None	None unless services fall outside medically necessary definition. Must be pre-certified.
Private duty nursing	T	None	None unless services fall outside medically necessary definition. Must be pre-certified.

Personal care services			
Habilitative services			
Case management/Care coordination	T	None	None unless services fall outside medically necessary definition.
Non-emergency transportation	T	None	None unless services fall outside medically necessary definition.
Interpreter services	T	None	Only when included as cost in FQHC setting
Other (Specify)			
Other (Specify)			
Other (Specify)			

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Scope and Range of health coverage provided including the types of benefit requirements:

HAWK-I:

HF 2517, Section 6.8(e)(1-14) describes the benefits to be included in the HAWK-I program, as adopted by the HAWK-I board in consultation with the Iowa Department of Human Services.

These include:

- Inpatient hospital services, including Medical, Surgical, ICU, Mental Health and Substance Abuse (MH/SA) services.
- Nursing care services including Skilled Nursing Facility (SNF) services.
- Outpatient hospital services including ER, surgery, laboratory, radiology and other services.
- Physician services, including:
 1. Surgical
 2. Medical
 3. Office Visits
 4. Newborn, well baby and well child care
 5. Immunizations
 6. Urgent Care
 7. Specialist Care
 8. Allergy testing and treatment
 9. MH/SA visits
- Ambulance services
- Physical therapy
- Speech therapy
- Durable Medical Equipment (DME)
- Home Health Care
- Hospice Care

- Prescription drugs
- Dental services including preventative services
- Hearing services as medically necessary
- Vision services including corrective lenses

Please refer to Table 3.2.1 for a detailed outline of benefits and limitations.

Benchmark Benefit Package:

A benchmark benefit package as specified by Title XXI, Section 2103, is as follows:

State employee coverage provided by Principal Health Care of Iowa Primary Care.

Principal Health Care of Iowa Primary Care (Principal Health) is an HMO coverage option available to Iowa State employees. Principal Health provides comprehensive coverage for hospital, surgical, physician, and other services. It is one of several plans offered to Iowa State employees in a multiple choice setting which include indemnity plans, PPOs, point of service plan and other HMOs. Principal Health was chosen as a benchmark due to its comprehensive benefit coverage and its large enrollment level of state employees. The benefit design of Principal Health is similar to a typical HMO, with an emphasis on preventative care and a primary care physician channeling mechanism.

Please highlight the level of preventive services offered and services available to children with special health care needs.

All health plans providing coverage for the HAWK-I program are required to provide preventative services to enrollees. Preventative services include newborn, well baby and well child-care, immunizations, vision services and preventative dental services. Additionally, each health plan provides case management for the special health needs population. Under the purview of Well Baby and Well Child lead testing is provided along with other standard lab tests. Family planning services are also available. Health plans also participate in community outreach and preventative care mailings to enrollees on child specific health topics. : (Attachment 6)

Medicaid Expansion:

The Medicaid expansion program follows regular Medicaid benefit guidelines as outlined in Table 3.2.1.

EPSDT Services are as follows:

Eligibility. All persons eligible for medical assistance under age 21 are

eligible for early and periodic screening, diagnosis, and treatment.

Screening services. Screening may be done by a screening center or other qualified providers. Other qualified providers are physicians, family and pediatric nurse practitioners, rural health centers, federally qualified health centers, clinics, and dentists. Screening services shall include all of the following services:

A comprehensive health and developmental history including an assessment of both physical and mental health development. This includes:

a. A developmental assessment.

b. An assessment of nutritional status.

A comprehensive unclothed physical examination. This includes:

a. Physical growth.

b. A physical inspection including ear, nose, mouth, throat, teeth, and all organ systems such as pulmonary, cardiac, and gastrointestinal.

Appropriate immunizations according to age and health history as recommended through the vaccines for children program.

Health education including anticipatory guidance.

Hearing and vision screening.

Appropriate laboratory tests. These shall include:

a. Hematocrit or hemoglobin.

b. Rapid urine screening.

c. Lead toxicity screening for all children aged 12 to 72 months.

d. Tuberculin test, when appropriate.

e. Hemoglobinopathy screening.

f. Serology, when appropriate.

Direct dental referral for children over age one.

Care Coordination for children with special health care needs.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
A. Comprehensive risk managed care organizations (MCOs)	Yes	Yes	
Statewide?	___ Yes <u>X</u> No	___ Yes <u>X</u> No	___ Yes ___ No
Mandatory enrollment?	___ Yes <u>X</u> No	<u>X</u> Yes ___ No Note: If MCO's are the only option in the county.	___ Yes ___ No
Number of MCOs	Four	Two	
B. Primary care case management (PCCM) program	Yes	No	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	Mental Health and Substance Abuse	No	

D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	Yes – Fee for services MediPass in counties where managed care programs are not available.	Yes – HAWK-I contracts with Wellmark Blue Cross/Blue Shield Classic Blue (Indemnity) in the counties that are not covered by MCO's. Wellmark indemnity plan is paid a capitated rate but the enrollee is not assigned a PCP.	
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

__X_ Yes, check all that apply in Table 3.3.1
(HAWK-I ONLY)

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter “NA.”

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ___ Yes_X___ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5				
Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	20%	20%	None	\$
Self-employment expenses	20%	20%	None	\$
Alimony payments Received	NA	NA	None	\$
Paid - Court Ordered	Entire amount paid and verified	Entire amount paid and verified	None	\$
Child support payments Received	\$50.00	\$50.00	None	\$
Paid (Eligible Group - court ordered and to a child not in the home. Not Eligible Group - verified to child not in the home.	Entire amount paid	Entire amount paid	None	\$
Child care expenses	\$175.00 age 2 and over \$200.00 under age 2	\$175.00 age 2 and over. \$200.00 under age 2	None	\$
Medical care expenses	NA	NA	None	\$
Gifts	\$30.00 per person per calendar quarter	\$30.00 per person per calendar quarter	NA if one time gift.	\$

Other types of disregards/deductions (specify) Babysitting in your home	40% of gross income (or actual expenses if in excess of 40%) to determine net profit. 20% of net profit	40% of gross income (or actual expenses if in excess of 40%) to determine net profit. 20% of net profit	None	\$
--	--	--	------	----

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____ _____
Premiums	None	Families with income between 150% and 185% of the FPL are required to pay a \$10.00 premium per child per month or \$20.00 premium maximum per family.	
Enrollment fee	None	None	
Deductibles	None	None	
Coinsurance/copayments**	None	Family with income between 150% and 185% of the federal poverty level are charged a \$25.00 copay for non-emergent ER visits (prudent layperson language is utilized)	

American Indian and Alaska Native children.		Not in this reporting period.	
---	--	-------------------------------	--

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**See Table 3.2.1 for detailed information.

- 3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Medicaid Expansion -- Not applicable

HAWK-I:

What is the level of premiums and how do they vary by program, income, family size, or other criteria?

Premiums: \$10 per child per month, with a maximum of \$20 per family for families whose countable income is equal to or greater than 150% of the federal poverty level.

How often are premiums collected?

When the third party administrator notifies the family of their eligibility to participate in the program, the applicant shall pay any premiums due within 10 working days for the initial month of coverage. When the premium is received, the third party administrator notifies the plan of the enrollment. After the initial month of coverage, premiums shall be received no later than the last day of the month prior to the month of coverage. Failure to pay the premium by the last day of the month before the month of coverage shall result in disenrollment from the plan (note: the premium is considered paid by the last day of the month if it is postmarked on or before last day of month). At the request of the family, premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

What do you do if families fail to pay the premium?

Failure to pay the premium by the last day of the month before the month of coverage shall result in disenrollment from the plan. A child may be reinstated once in a 12-month period when the family fails to pay the premium by the last day of the month prior to the month of coverage. However, reinstatement must occur within the calendar month following the month of nonpayment

and the premium must be paid in full prior to reinstatement.

Is there a waiting period (lock-out) before a family can re-enroll? No

Once a child is cancelled from the program due to nonpayment of premiums, the family may reapply at anytime. However, coverage will not be effective until the 1st day of the month following the month of application.

Do you have any innovative approaches to premium collection?

Premiums may be paid in advance, in the form of cash or personal checks.

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

☒ Employer

☒ Family

☒ Absent parent

☒ Private donations/sponsorship

☒ Other (specify) We have no restrictions on who can pay the premium on behalf of the family.

3.3.3 If enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

NA

1.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

NA

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

The family receives a billing statement from the third party administrator.

There are only two forms of cost sharing in the HAWK-I program. In both cases, they apply only to families with income that equals or exceeds 150% of the federal poverty level.

1. Premiums of \$10 (\$120 annually) per child per month with a family maximum of \$20 (\$240 annually); and
2. A \$25 copayment for inappropriate use of the emergency room.

At current poverty levels, the family would have to incur the number of inappropriate emergency room visits indicated below to exceed 5%. Health plans will report enrollee ER usage, resulting in a copayment obligation, to the third party administrator. The third party administrator will track the ER copayment to ensure cost sharing does not exceed 5% of family income. At the point the ER copayment results in cost sharing exceeding 5%, enrollees will be reimbursed for the cost.

It is expected that the health plans will intervene to educate enrollees about the appropriate use of ER services prior to any family utilizing the ER inappropriately in as many instances indicated in the chart.

HH Size	Annual Income at 150% FPL	5%	Premium Maximum		No. of Annual Inappropriate ER Visits
1	\$12,075	\$603.75	\$120	(\$483.75/\$25)	19
2	\$16,275	\$813.75	\$240	(\$573.75/\$25)	22
3	\$20,475	\$1,023.75	\$240	(\$783.75/\$25)	31
4	\$24,675	\$1,233.75	\$240	(\$993.75/\$25)	39
5	\$28,875	\$1,443.75	\$240	(\$1,203.75/\$25)	48
6	\$33,075	\$1,653.75	\$240	(\$1,413.75/\$25)	56

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

- ☐ Shoebox method (families save records documenting cumulative level of cost sharing)
- ☒ **Health plan administration (health plans track cumulative level of cost sharing)** Health plans provide encounter data regarding the \$25.00 emergency room copayment to the third party administrator.
- ☐ Audit and reconciliation (State performs audit of utilization and cost sharing)
- ☒ **Other (specify)** The third party administrator tracks information on copayments from the health plan and tracks the premiums.

3.3.7 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

No families have hit the 5 percent cap since the HAWK-I program was implemented.

3.3.8 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

HAWK-I:

The state is currently collecting data on disenrollments. Approximately 11% of families have been disenrolled due to lack of premium payment.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (T=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1						
Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Billboards						
Brochures/flyers	T	5	T	5		
Direct mail by State/enrollment broker/administrative contractor	T	3	T	3		
Education sessions	T	5	T	5		
Home visits by State/enrollment broker/administrative contractor	T	5	T	5		
Hotline	T	4	T	4		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	T Hotline	3	T Hotline	3		
Prime-time TV advertisements	T	3	T	3		
Public access cable TV						
Public transportation ads	T	2	T	2		
Radio/newspaper/TV advertisement and PSAs	T	4	T	4		
Signs/posters	T	3	T	3		
State/broker initiated phone calls/mailings	T	3	T	3		

<u>Wic , Visiting Nurses, Maternal and Child Health Clinics</u>	T	4	T	4		
<u>School Nurse or Teacher</u>	T	5	T	5		
<u>Newspaper</u>	T	4	T	4		
<u>Community Organization (Headstart, Community Action Agencies, AEA, MICA</u>	T	4	T	4		
<u>Doctor, Pharmacist or Hospital</u>	T	4	T	4		
<u>Department of Human Services</u>	T	5	T	5		
<u>Friend/Family</u>	T	4	T	4		
<u>Caring Program</u>	T	2	T	2		
<u>Clergy</u>	T	1	T	1		

NOTE: Approximately 40% of applications submitted to the HAWK-I third party administrator are referred to Medicaid.

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.2 **Where does your CHIP program conduct client education and outreach?**

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (T=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2						
Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program*	
	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)	T = Yes	Rating (1-5)
Battered women shelters	T	1	T	1		
Community sponsored events (school conferences)	T	4	T	4		
Beneficiary's home (visiting nurses)	T	2	T	2		
Day care centers	T	3	T	3		
Faith communities	T	2	T	2		
Fast food restaurants /Convenience Stores	T	2	T	2		
Grocery stores						
Homeless shelters						
Job training centers	T	3	T	3		
Laundromats						
Libraries	T	3	T	3		
Local/community health centers	T	4	T	4		
Point of service/provider locations	T	5	T	5		
Public meetings/health fairs	T	3	T	3		
Public housing	T	2	T	2		
Refugee resettlement programs	T	2	T	2		
Schools/adult education sites	T	5	T	5		
Senior centers						

Social service agency	T	4	T	4		
Workplace (If a business is being closed or the business does not provide insurance to part time employees e.g. temp agencies)	T	2	T	2		
Insurance Agents	T	3	T	3		

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

The State has developed enrollment goals for each county for both the Medicaid expansion and HAWK-I programs. Each county or cluster of counties is required to develop an outreach plan designed to meet their enrollment goals. Enrollment data is gathered monthly and distributed to the counties so they can monitor their progress. Additionally, the counties are required to provide quarterly activity reports that describe their activities as well as their successes and barriers.

(Attachment 7)

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Applications are available in English and Spanish. Additionally, bi-lingual staff are available at the 1-800 customer service center. Community outreach activities involve local ethnic populations.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

We do not have sufficient data to measure the success of these activities during the reporting period.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of Coordination	Medicaid*	Maternal & Child Health	Other (specify) Schools
Administration	Both the HAWK-I program and Medicaid (including the Medicaid expansion under S-CHIP) are administered by the Division of Medical Services within the Department of Human Services	NA	NA
Outreach	Outreach activities are targeted at both HAWK-I and Medicaid. Counties have been given enrollment targets or both programs.	Maternal and Child Health centers are active in outreach for the SCHIP program. They are included as community partners in developing outreach plans and distribute materials and conduct other outreach activities. In some counties, the MCH is the lead outreach agency.	Many school districts have added a release of information to their application for free and reduced lunches that allows the child's name to be released to the State's SCHIP program for outreach. School nurses are actively involved in outreach activities, including the development of community outreach plans.
Eligibility Determination	An automatic referral process is in place so that if a child is not eligible for Medicaid, they are automatically referred to HAWK-I. (Attachment 8)	NA	NA
Service Delivery	Medicaid eligibility workers are co-located with HAWK-I staff to determine eligibility of applicants who are referred to Medicaid through the Medicaid screen and enroll process.	<i>MCH's provide some of the services covered under the SCHIP program (i.e. immunizations) and some are participating providers in the health plans (Note: Each health plan is responsible for contracting with an adequate provider panel which may or may not include MCH's).</i>	NA
Procurement	NA	NA	NA
Contracting	NA	NA	NA
Data Collection	The third party administrator collects data	NA	NA

	specifically related to HAWK-I. However, the Medicaid program provides data regarding the Medicaid expansion component of the S-CHIP program.		
Quality Assurance	Shellie – add something here about the joint reviews of health plans that participate in both programs or whatever else you can think of.	NA	NA
Other (specify)			

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

All the crowd-out measures described below apply only to the HAWK-I program. There are no crowd-out measures implemented for the Phase I Medicaid expansion provisions of the S-CHIP program.

☒ **Eligibility determination process:**

☒ **Waiting period without health insurance (specify).** A 6-month waiting period is applied when employer-sponsored health care coverage is voluntarily dropped in order to enroll in the HAWK-I program. The 6-month waiting period does not apply in situations where an economic hardship can be established. Economic hardship is considered to exist when the cost of the employer-sponsored health care coverage exceeds 5% of the family's gross annual income.

☒ **Information on current or previous health insurance gathered on application (specify).** The application requests information about current and previous health insurance coverage, including the last date of coverage, cost, and why it was dropped. (**Attachment 9**)

☒ **Benefit package design:**

☒ **Cost sharing (specify).** While cost-sharing was not specifically designed to deter crowd-out, it may have that effect in some cases. Cost sharing is limited to premiums of \$10 per child per month with a \$20 family maximum and a \$25 emergency room

copayment for treatment of non-emergent medical conditions. Cost sharing applies only to families with income equal to or in excess of 150% of FPL.

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

The State will track responses on applications regarding previous coverage. There was not sufficient data during the reporting period to make any conclusions as to whether crowd-out is an issue. Anecdotally, we do not believe crowd-out is a major concern.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

(Attachment 10)

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

Length of enrollment (number of month) and how this varies by characteristics of children and families, as well as across programs is not captured at this detail.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

Table 4.1.1 CHIP Program Type <u>Mathematica will submit data for this table..</u>						
Characteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children						

Age						
Under 1						
1-5						
6-12						
13-18						
Countable Income Level*						
At or below 150% FPL						
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						

13-18						
At or below 150% FPL						
Above 150% FPL						
Type of plan						
Fee-for-service						
Managed care						
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

During the reporting period HAWK-I developed a baseline survey to capture coverage by health insurance prior to being enrolled in S-CHIP.

All families participating in the HAWK-I program will be asked to complete a Functional Health Assessment Survey (developed as a modification of a CHAPS instrument) at the time they apply and annual thereafter. The initial survey ask questions about the family's experience in accessing health care prior to becoming eligible for the HAWK-I program in order to establish a baseline. The first baseline survey results were released October, 1999, the second on January, 1999.
(Attachment 11)

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

4.2 Who disenrolled from your CHIP program and why?

- 4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

How many children disenrolled from your CHIP program(s)? 461 disenrolled.

Please discuss disenrollment rates presented in Table 4.1.1. The total number disenrolled reflected in Table 4.1.1. reflects disenrollees beyond the reporting period. The HAWK-I Disenrollment Report covers months January 1, 1999 through November , 1999. The high number of disenrollees due to Medicaid enrollment is the result of retroactive eligibility under Medicaid. Disenrollment due to no premium payment is equal to 11% of the total population enrolled under the HAWK-I program. The HAWK-I program allows one grace period before they are disenrolled from the program.

How to disenrollment rates compare to traditional rates?

We are not clear on what “traditional rates” are. Therefore, a comparison could not be made at this time.

- 4.2.2 **How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?** During the reporting period none of the children in HAWK-I were up for renewal.

4.2.3 **What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)**

Table 4.2.3						
Reason for discontinuation of coverage	Medicaid CHIP Expansion Program Discontinuation Statistics are not available for Medicaid.		State-designed CHIP Program Disenrollment Reason by County report as of the end of November, 1999. Detailed discontinuation of coverage is only available January 1, 1999 through November, 1999.		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total			643	100%		
Access to commercial insurance			78	12%		
Eligible for Medicaid			184	29%		
Income too high						
Aged out of program			18	4%		
Moved/died			5	1%		
Nonpayment of premium			284	44%		
Incomplete documentation						
Did not reply/unable to contact						
Other (specify) Not Living in Household			12	2%		

Other (specify) Voluntary Withdrawal			53	8%		
Don't know	X					

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.2.3 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Once a child is cancelled from the program due to nonpayment of premiums, the family may reapply at anytime. However, coverage will not be effective until the 1st day of the month following the month of application.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____

FFY 1999 _____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type ____ Mathmatica is providing this information.				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures				
Premiums for private health insurance (net of cost-sharing offsets)*				
Fee-for-service expenditures (subtotal)				
Inpatient hospital services				

Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				

Other services				
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4.3.2 **What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.**

What types of activities were funded under the 10 percent cap?

Outreach, third party administrator, promotional material, state staff, systems development, functional assessment survey, cost associated with HAWK-I board and program start-up costs.

What role did the 10 percent cap have in program design?

The 10% cap has effectively limited outreach activities because the State did not have an additional appropriation to apply against those costs.

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program*	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach				\$457,213		
Administration	\$30,707	\$271,397		\$692,639		
Other _____						
Federal share						
Outreach				\$339,801		
Administration	\$22,916	\$201,702		\$514,769		
Other _____						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.3.3 **What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))**

- ___ State appropriations
- ___ County/local funds
- ___ Employer contributions
- X** **Foundation grants**
- ___ Private donations (such as United Way, sponsorship)
- ___ Other (specify) _____

4.3 How are you assuring CHIP enrollees have access to care?

Medicaid/Medicaid Expansion:

MediPass (PCCM) – Provider Contract Requirements
HMO – Provider Panel Review Quarterly

HAWK-I:

MCO – Provider contract requirements
Indemnity: -- Provider contract requirements

4.4.1 **What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify ‘MCO.’ If an approach is used in fee-for-service, specify ‘FFS.’ If an approach is used in a Primary Care Case Management program, specify ‘PCCM.’**

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits	PCCM	MCO/FFS (Indemnity)	
PCP/enrollee ratios	MCO/PCCM	MCO/FFS (Indemnity)	
Time/distance standards	MCO/PCCM	MCO/FFS ** (Indemnity)	
Urgent/routine care access standards	MCO/PCCM	MCO/FFS (Indemnity)	
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO	MCO/FFS ** (Indemnity)	
Complaint/grievance/disenrollment reviews	MCO/PCCM	MCO/FFS (Indemnity)	
Case file reviews		MCO/FFS ** (Indemnity)	
Beneficiary surveys	MCO/PCCM	MCO/FFS (Indemnity)	
Utilization analysis (emergency room use, preventive care use)	PCCM	MCO/FFS (Indemnity)	
		** HAWK-I contacts with our local PRO to perform annual on-site reviews.	
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2			
Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requiring submission of aggregate HEDIS data by health plans	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (specify) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

We do not have sufficient data to measure the success of these activities during the reporting period.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The HAWK-I program will analyze availability (adequate access) of primary care providers/sub-specialists, mental health providers, dentists, via Geo Mapping and Geo Access beginning July 1, 2000.

HAWK-I health plans are required develop and utilize satisfaction survey instruments and report the finding to HAWK-I annually.

The HAWK-I program currently is has developed a baseline survey mailed to each household. We will follow-up, once the program has been implemented for one year, an evaluation survey tool. The evaluation survey tool will evaluate:

- 1) Patient perception of access (regular office hours, office hours on any nights, Saturday morning, weekends).
- 2) Objective measures of patient access (travel time, wait time in office; and days to wait for an appointment etc.)

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	Immunization, EPSDT, Birth Review Study.	Asthma, ER Usage, Immunizations, Well Child Visits, Preventative Dental Visits.	
Client satisfaction surveys	MCO/PCCM	MCO/Indemnity	
Complaint/grievance/disenrollment reviews	MCO/PCCM	MCO/Indemnity	
Sentinel event reviews	MCO	MCO/Indemnity	
Plan site visits	MCO	MCO/Indemnity	
Case file reviews		MCO/Indemnity	
Independent peer review	EQRO-MHCAC-University of Iowa Public Policy Center	MCO/Indemnity	
HEDIS performance measurement	MCO	MCO/Indemnity	
Other performance measurement (specify)			
Other (specify) _____			
Other (specify) _____			

Other (specify) _____			
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*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Medicaid Expansion: Information is not separated from Iowa Medicaid – Comparison Report, HMO EQRO visits.

HAWK-I: We do not have sufficient data to measure the success of these activities during the reporting period

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

HAWK-I: Health plan EQRO visits annually, Evaluation survey (satisfaction), Hedis quality measurements, Geo Mapping, Geo Access of Health Plan provider panels, random chart reviews pulled from encounter data. Data will be available in FFY 2000/2001.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program’s performance. Please list attachments here. Brochure, application, poster, comparison chart additional attachments are addressed throughout the report. **(Attachment 12)**

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn’t work when designing and implementing your CHIP program? What lessons have you learned? What are your “best practices”? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn’t work. Be as specific and detailed as possible. (Answer all that apply. Enter ‘NA’ for not applicable.)

1.1.1 Eligibility Determination/Redetermination and Enrollment

Generally, we have been happy with the processes we have established for eligibility determination and enrollment into the program. With the elimination of the face-to-face interview requirement for Medicaid in July, 1999, we were able to co-locate Medicaid eligibility staff with HAWK-I staff. This has greatly streamlined the process. No redetermination has been completed for the HAWK-I program during this reporting period. Iowa's Medicaid program continues to require monthly reporting which has proven to be a barrier. We have introduced legislation to allow 12 months of continuous eligibility in the Medicaid program.

What has not worked well is the mandatory screening and enrolling requirement for Medicaid. Many of the people that apply for HAWK-I do not want Medicaid. As a result, while we spend a significant amount of resources to get people to apply for HAWK-I, they ultimately remain uninsured because they are referred to Medicaid. If the goal of the program is to insure children, families need to be allowed the choice of programs in which to participate.

5.1.2 **Outreach**

Iowa's initial outreach activities focused primarily on media. While we believe this approach was effective to introduce the "product" to the general public, it was not effective in motivating people to apply for the program. In July 1999, the State kicked off a grassroots outreach campaign that set enrollment goals for communities and empowers communities to develop their own outreach strategies. At the same time, the State will continue to develop state-wide outreach strategies such as identifying corporate sponsors, working with other state agencies, and providing technical assistance to community outreach groups. This process was just getting underway during the reporting period.

5.1.3 **Benefit Structure**

We believe the benefit structure is more than adequate to meet the needs of average children. The State is conducting a functional health assessment survey to measure the health status of children when they enter the HAWK-I program and again after they have been in the program for one year. The results of this survey will set a baseline by which to measure the effectiveness of the HAWK-I program and identify unmet needs. Additionally, the Clinical Advisory Group and the Children With Special Health Care Needs Advisory Group will provide input to the HAWK-I Board on ways to improve the benefit structure of the program.

5.1.4 **Cost-Sharing (such as premiums, copayments, compliance with 5% cap)**

The State is satisfied with the cost-sharing methodology established for the HAWK-I program. It is easily administered and tracked and is easily understood by program participants. There have been no discussions around changing the cost sharing provisions of this program.

5.1.5 **Delivery System**

Providing benefits through contracts with commercial health plans has proven to be popular among program participants. In many counties there is a choice among plans and participants like getting an insurance card from a commercial carrier rather than a state-generated card. The HAWK-I program is also being readily accepted by providers who were traditionally reluctant to participate in the Medicaid program due to the low reimbursement rates. The reimbursement rate in the HAWK-I program is based on the insurance plan's commercial products.

5.1.6 **Coordination with Other Programs (especially private insurance and crowd-out)**

We are having difficulty developing a policy to address situations where individuals, who have been approved for the HAWK-I program, become retroactively eligible for Medicaid. Participating health plans do not feel they should pay claims when the person has been made eligible for Medicaid, yet they do not like retroactive cancellations of coverage and subsequent adjustment of claims. We have asked HCFA to clarify which plan is the primary payor in these situations and have not received a final response.

5.1.7 **Evaluation and Monitoring (including data reporting)**

Encounter data will be submitted by each contracted health plan utilizing a standardized format. Satisfaction survey instruments mailed to enrollees at least annually by health plans and the HAWK-I administrative program. Random chart reviews tied to goals and objectives. Geo Mapping & Geo Access to monitor adequate access. Demographic reports (identify concentration of ethnic populations), administrative quality reviews of third party administrator. Grassroots community based outreach best practice reports. Annual external quality review provided by a contracted PRO agency for each contracted HAWK-I health plans, fraud and abuse reports. Administrative quality review of HAWK-I third party administrator eligibility determination practices, logging of premium payments timely, timely application processing etc.

5.1.8 **Other (specify)**

5.2 **What plans does your State have for “improving the availability of health insurance and health care for children”? (Section 2108(b)(1)(F))**

The HAWK-I program has offered statewide coverage since March 1, 1999. Effective April 1, 1999 John Deere health plan signed a contract to provide coverage in 17 counties in Iowa providing choice between plans in each of these counties. We welcome other health plans in the state to begin providing coverage under the HAWK-I program. Additionally, Iowa is working in collaboration with other agencies to develop quality care guidelines that reach across all state agencies providing health care to children in Iowa under the Comp

Care project. .

1.2 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

1. Give states more flexibility around buy-in of employer sponsored health care.
2. Allow underinsured children to participate.
3. Allow dependents of State employees to participate.
4. Allow families choice between Medicaid and the separate S-CHIP program.
5. Remove the 10% cap on administration and outreach.

Addendum to Table 3.1.1

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999**. Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here and indicate who you passed it along to. Name _____, phone/email _____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups	___ Gross	___ Net	___ X ___ Both
Title XXI Medicaid SCHIP Expansion	___ Gross	___ Net	___ X ___ Both
Title XXI State-Designed SCHIP Program	___ X ___ Gross	___ Net	___ ___ Both
Other SCHIP program _____	___ Gross	___ Net	___ Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups **185 %** of FPL for children under age **~~1~~___**

	133 %	of FPL for children aged	__	1 thru _5____
	100%	of FPL for children aged	__	6 thru 14____
	37%	of FPL for children aged		15 thru 18
Title XXI Medicaid SCHIP Expansion	133%_	of FPL for children aged	__	6 thru 18_(children born after 9/30/83)
		of FPL for children aged	__	
		% of FPL for children aged	_____	
Title XXI State-Designed SCHIP Program	185%	of FPL for children aged		<u>0 thru 18 years</u>
Other SCHIP program_____		% of FPL for children aged	_____	
		% of FPL for children aged	_____	
		% of FPL for children aged	_____	

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter “Y” for yes, “N” for no, or “D” if it depends on the individual circumstances of the case.

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	D	D	D	
All relatives living in the household	N	N	N	
All individuals living in the household	N	N	N	
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.
Enter “C” for counted, “NC” for not counted and “NR” for not recorded.

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings (unless specifically exempted)	C	C	C	
Earnings of dependent children (if not a full-time student)	C	C	C	
Earnings of students (if full time)	NC	NC	NC	
Earnings from job placement programs	C	C	C	
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America) Americorps	NC (living allowance for VISTA) C (stipends for other Americorp Program)	NC C	NC	
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC	NC	
Education Related Income Income from college work-study programs	NC	NC	NC	
Assistance from programs administered by the Department of Education	NC	NC	NC	
Education loans and awards	NC	NC	NC	
Other Income Earned income tax credit (EITC)	NC	NC	NC	

Alimony payments received	C	C	C	
Child support payments received	C (minus \$50 exemption)	C (minus \$50 exemption)	C	
Roomer/boarder income	C	C	C	
Income from individual development accounts	NC	NC	NC	
Gifts	C (exempt \$30 per person per calendar quarter if the gift does not exceed \$30)	C (exempt \$30 per person per calendar quarter if the gift does not exceed \$30)	NC	
In-kind income	NC	NC	NC	
Program Benefits Welfare cash benefits (TANF)	NC	NC	NC	
Supplemental Security Income (SSI) cash benefits	NC	NC	NC	
Social Security cash benefits	NC	NC	C	
Housing subsidies	NC	NC	NC	
Foster care cash benefits	NC	NC	NC	
Adoption assistance cash benefits	NC	NC	NC	
Veterans benefits	C	C	C	
Emergency or disaster relief benefits	NC	NC	NC	
Low income energy assistance payments	NC	NC	NC	
Native American tribal benefits	NC	NC	NC	
Lottery Winnings that are paid out annually.(Recurring lump sum income) Earned and unearned lump sum income that is received on a regular basis shall be counted and prorated over the time it is intended to cover. These payment may include, but are not limited to: 1. Annual bonuses 2. Lottery winnings that are paid out annual	C	C	C	

Nonrecurring lump sum income. Nonrecurring lump sum income is income that is not expected to be received more than once. These payments may include, but are not limited to: 1. An inheritance 2. A one-time bonus 3. Lump sum lottery winnings 4. Other one-time payments.	C	C	NC	
Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.	NC	NC	NC	
Value of the United States Department of Agriculture donated food(surplus commodities).	NC	NC	NC	
Value of supplemental food assistance received under the Child nutrition Act and the special feed service program for children under the National School Lunch Act.	NC	NC	NC	
Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.	NC	NC	NC	
Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.	NC	NC	NC	
Interest and Dividend Income	NC	NC	NC	
Any judgement funds that have been or will be distributed per capita or held in trust for members of any Indian Tribe.	NC	NC	NC	
Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.	NC	NC	NC	
Tax-exempt portions of payment made pursuant to the Alaskan Native Claims Settlement	NC	NC	NC	

The value of the coupon allotment in the Food Stamp program.	NC	NC	NC	

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	<u> X </u> No	<u> </u> Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	<u> X </u> No	<u> </u> Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	<u> X </u> No	<u> </u> Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	<u> </u> No	<u> </u> Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter “NA.”

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State- designed SCHIP Program (C)	Other SCHIP Program* (D)
Countable or allowable level of asset/resource test	NA	NA	NA	\$
Treatment of vehicles: Are one or more vehicles disregarded? <i>Yes or No</i>	NA	NA	NA	
What is the value of the disregard for vehicles?	NA	NA	NA	\$
When the value exceeds the limit, is the child ineligible(“I”) or is the excess applied (“A”) to the threshold allowable amount for other assets? <i>(Enter I or A)</i>	NA	NA	NA	

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes **X** No

Medicaid and Medicaid Expansion eligibility rules have not changed.

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? **X** Yes ___ No

HAWK-I has changes eligibility rules since September 30, 1999.